

12397

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Calvert</i>		MARYLAND		STATE <i>Virginia</i> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Telegraphman</i>		LENGTH OF STAY (in this place) <i>15 months</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Portsmouth</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <i>300 Pearl St</i>			
3. NAME OF DECEASED: (First) <i>Bernard</i> (Middle) <i>Ball</i> (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <i>Dec 17, 1955</i>			
5. SEX: <i>M.</i>	6. COLOR OR RACE: <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <i>Feb. 4 1898</i>	9. AGE last birthday <i>57</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>carrier</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Canning</i>		11. BIRTHPLACE (State or foreign country): <i>Portsmouth Va</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.</i>	
13. FATHER'S NAME: <i>Unknown</i>				14. MOTHER'S MAIDEN NAME: <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <i>228-24-4354</i>		17. INFORMANT & ADDRESS: <i>Lucy Ball Telegraphman Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <i>cardiac vascular disease</i>				<i>4 yrs</i>			
ANTECEDENT CAUSE (B) <i>arteriosclerosis</i>				<i>1 yr</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Aug</i> , 19 <i>55</i> , to <i>Dec 17</i> , 19 <i>55</i> that I last saw the deceased alive on <i>Dec 16</i> , 19 <i>55</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Wm. R. Reddy</i>		ADDRESS <i>Telegraphman</i>		DATE SIGNED <i>Dec 18 1955</i>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <i>1/3 1956</i>		NAME OF CEMETERY OR CREMATORY <i>Univ. of Md. Med. School</i>		LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>JAN 10 1956</i>		REGISTRAR'S SIGNATURE <i>Wm. R. Reddy</i>		24. FUNERAL DIRECTOR <i>Wm. R. Reddy</i>		ADDRESS <i>Telegraphman</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12548

BUREAU V. S.

JAN 11 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12367

CERTIFICATE OF DEATH

12349

Item 7, Film G190 12-23-55 et

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Talbot		MARYLAND		STATE Md		COUNTY Kent	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Easton		5 days 6 hrs 20 min		TOWN Still Pond		14X-2	
HOSPITAL OR STREET ADDRESS Memorial Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Annie (Middle) (Last) Baxter				(Month) (Day) (Year) December 5 1955			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH January 20 1873	9. AGE last birthday 82 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Maryland		USA	
13. FATHER'S NAME J. I. Zinel				14. MOTHER'S MAIDEN NAME Josephine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS			
				Mr. Norman Baxter (son)			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) Myocardial Infarction				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) Ruptured atherosclerotic plaque.							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Atherosclerosis							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
[Signature]				C. G. [Signature] 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Dec. 8 1955		Chesler Cemetery		Chesler Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 12/7/55		H. A. Neerues		Marvin V. Williams		Chesler Ind	

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 13 1955

RECEIVED

12368

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Talbot</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Talbot</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>	LENGTH OF STAY (in this place) <u>Life</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>40 Easton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>123 Locust St</u>	STREET ADDRESS (If rural give location) <u>123 Locust</u>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Mable</u>	(Middle)	(Last) <u>Beamus</u>	DATE OF DEATH: <u>12</u> <u>17</u> <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>7/21/1908</u>
9. AGE last birthday: <u>55</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Beamus</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Hicks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, Give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Remona Moore Easton, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma of Cervix</u>			<u>1 year</u>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>18/5/55</u>	19B. MAJOR FINDINGS OF OPERATION: <u>Ca of Cervix (Squamous cell)</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	21F. HOW DID INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
22. I hereby certify that I attended the deceased from <u>8/5/55</u> 19 <u>55</u> , to <u>12/17</u> , 19 <u>55</u> that I last saw the deceased alive on <u>12/16</u> , 19 <u>55</u> , and that death occurred at <u>6 A.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>J.T.B. Ambler</u>		ADDRESS <u>M.D. Easton, Md.</u>	DATE SIGNED <u>12/21/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>12/22/55</u>	NAME OF CEMETERY OR CREMATORY <u>Richards Cem</u>	LOCATION (City, town, or county) (State) <u>Easton, Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>12-21-55</u>	REGISTRAR'S SIGNATURE <u>N.A. Neerice</u>	24. FUNERAL DIRECTOR <u>James D. Doherty</u> ADDRESS <u>Easton, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

DEC 28 1955

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12369 CERTIFICATE OF DEATH

12351

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Easton</u>		<u>Life</u>		TOWN <u>Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>202 Port st.</u>				<u>4210 Dover st.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Sheryl E Bently</u>				<u>12 1 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>ca</u>	<u>Single</u>	<u>9/12/55</u>	<u>2</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					<u>Maryland</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Wendell Bently</u>				<u>Elaine Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mrs Elaine Taylor</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				16. MEDICAL CERTIFICATION			
762.0 IMMEDIATE CAUSE (A) <u>Asphyxia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hours</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/1</u> 19 <u>55</u> to <u>12/1</u> 19 <u>55</u> , that I last saw the deceased alive on <u>12/1</u> 19 <u>55</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Raymond T. Melt</u> M.D.				DATE SIGNED <u>12/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/7/55</u>		<u>Richards Cem</u>		<u>Easton, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>12/5/55</u>		<u>N.H. Newries</u>		<u>James B. Oschell</u>		<u>Easton, Md</u>	

VS A19C 1-55 10M

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

4095192405

DEATH CERTIFICATE OF DEATH

DATE OF DEATH

IN THE CITY OF BOSTON

MASSACHUSETTS

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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BUREAU V. S.

DEC 9 1965

RECEIVED

RECEIVED
BUREAU OF VITAL RECORDS
MASSACHUSETTS DEPARTMENT OF HEALTH
BOSTON, MASSACHUSETTS
DEC 9 1965

1

12352

12370

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Easton</u>		<u>Life</u>		TOWN <u>Easton</u>		<u>40</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hammond St</u>				STREET ADDRESS (If rural give location) <u>Hammond</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>John</u> (Middle) <u>westley</u> (Last) <u>Blackson</u>				(Month) <u>Dec</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Male</u>	<u>Col</u>	<u>Married</u>	<u>6/15/76</u>	<u>79</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>Domestic</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John W. Johnson</u>				<u>Mary S. Gibbs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
177X IMMEDIATE CAUSE (A)				<u>Carcinoma of prostate gland</u>			
ANTECEDENT CAUSE(S) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>1-2 years</u>			
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 26</u> , 19 <u>55</u> , to <u>Dec 3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 3</u> , 19 <u>55</u> , and that death occurred at <u>5:15</u> A.M. from the causes and on the date stated above. <u>12/5/55</u>							
SIGNATURE <u>Hayward T. Melt</u>				DATE SIGNED <u>12/5/55</u>			
M.D. <u>MD</u>				ADDRESS (Street, city, town, state) <u>633 W. 1st St. Easton, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/6/55</u>		<u>Richards Bur.</u>		<u>Easton, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DATE 12-5-55</u>		<u>N. H. Nevers</u>		<u>James D. Dandridge</u>		<u>Easton, Md.</u>	

VS AISC 1-55 10M

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

BUREAU V. 3

DEC 9 1955

RECEIVED

12371

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY Talbot	MARYLAND	STATE Md.	COUNTY Talbot
CITY (If outside corporate limits, write RURAL OR and give nearest town) 40 Easton	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) Easton Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 80 Memorial Hospital		STREET ADDRESS (If rural give location) 1	
3. NAME OF DECEASED (First) (Middle) (Last) Thomas Elwood Blades		4. DATE (Month) (Day) (Year) OF DEATH: Dec. 2 1955	
5. SEX: Male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH: July 3, 1920
9. AGE last birthday: 35 yrs.		IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): St. Michaels Utilities - Linesman		10B. KIND OF BUSINESS OR INDUSTRY: Caroline Co. Md.	
11. BIRTHPLACE (State or foreign country): U.S.		12. CITIZEN OF WHAT COUNTRY: U.S.	
13. FATHER'S NAME: Wm. Milton Blades		14. MOTHER'S MAIDEN NAME: Florence Foster	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) yes World War II		16. SOCIAL SECURITY NO. 212 -18 - 6596	
17. INFORMANT & ADDRESS: Clyde Blades Easton, Md.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
819X IMMEDIATE CAUSE (A) Fractured skull - penetrating			Immediate
ANTECEDENT CAUSE (B) Auto accident			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) road	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) Easton Talbot Md			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 12 2 55 11 30 P.M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
21F. HOW DID INJURY OCCUR? Pass. in car which struck tree			
22. I hereby certify that I attended the deceased from ., 19 ., to ., 19 ., that I last saw the deceased alive on ., 19 ., and that death occurred at ., M. from the causes and on the date stated above.			
SIGNATURE Louis White		DATE SIGNED 12-3-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery	
DATE THEREOF 12-5-55		LOCATION (City, town, or county) (State) Easton, Talbot Md.	
DATE REC'D BY LOCAL REGISTRAR 12/3/55		REGISTRAR'S SIGNATURE N.H. Newnam	
24. FUNERAL DIRECTOR Maurice E. Newnam & Son		ADDRESS Easton, Md.	

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

3 2 11

MARYLAND STATE DEPARTMENT OF HEALTH
12372 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

12354

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u> LENGTH OF STAY (in this place) <u>D.O.A.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Queen Anne</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Grasonville</u> STREET ADDRESS (If rural, give location) _____	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Bruce</u> <u>Carter</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12</u> <u>14</u> <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Infant</u>	8. DATE OF BIRTH <u>9-10-1955</u>
9. AGE last birthday <u>4 months</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Welford Carter</u>		14. MOTHER'S MAIDEN NAME <u>Thelma Gray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) <u>This baby was dead on arrival at hospital - it was evidently labor pneumonia</u> Antecedent cause(s) (b) <u>2 short duration</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: ☒ natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☒ Conterville md

SIGNATURE <u>W. Henry Fisher M.D. Deputy Med Exam for D.A. & M</u>		DATE SIGNED <u>11/14/55</u>	
23. BURIAL, CREMATION (Specify) <u>BURIAL</u>		DATE THEREOF <u>Dec 15-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Morgnetic Cemetery</u>		LOCATION (City, town, or county) (State) <u>Chester Town Md</u>	
DATE REC'D BY LOCAL REG. <u>12-14-55</u>		24. FUNERAL DIRECTOR <u>for Carl Boyer</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU A

DEC



12373 **CERTIFICATE OF DEATH**

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL or end of nearest town) <u>Easton</u>		LENGTH OF STAY (In this place) <u>3da.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>407 August St.</u>			
3. NAME OF DECEASED (Type or Print) <u>ASA</u> (First) <u>Cohée</u> (Middle) <u></u> (Last)				DATE OF DEATH <u>12-18</u> (Month) <u>19</u> (Day) <u>55</u> (Year)			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Dec 9, 1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Cohée</u>				14. MOTHER'S MAIDEN NAME <u>Emily Dill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs Cora Cohée</u>		
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Myocardial Infarct</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary thrombosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19... to 19..., that I last saw the deceased alive on 11/20/55, and that death occurred at 11:30 A.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>708 E. 10th St.</u> DATE SIGNED <u>12-20-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>12/20/55</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Easton (Talbot Co) Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS	
DATE <u>12-20-55</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. S.

DEC 28 1955

RECEIVED

12374

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Talbot</i>		MARYLAND		STATE <i>md.</i>		COUNTY <i>Talbot</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <i>Easton</i>		<i>1 day - 19 hrs</i>		<i>Easton Rd #1 - Box 224</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Memorial Hospital</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>Jacqueline</i>				<i>12 24 1955</i>			
5. SEX: <i>F</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>5</i>		8. DATE OF BIRTH: <i>11-11-55</i>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
yrs. <i>1</i>		Months <i>13</i>		Days <i>13</i>		Hours <i>13</i> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
						<i>Maryland</i>	
13. FATHER'S NAME: <i>Herbert De Shields</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS:	
<i>No</i>						<i>Herbert De Shields</i>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) <i>Pyelonephritis</i>			
ANTECEDENT CAUSE (B)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/22</i> , 1955, to <i>12/24</i> , 1955, that I last saw the deceased alive on <i>12/24</i> , 1955, and that death occurred at <i>3:30 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				ADDRESS <i>Easton</i>		DATE SIGNED <i>30 Dec 1955</i>	
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>12-26-55</i>		<i>Unionville</i>		<i>Easton Md RD 7</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>12-25-55</i>		<i>N.H. Neerun</i>		<i>J.B. Russell</i>		<i>Easton</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 6

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12357

12375

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>		STATE <u>Maryland</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		LENGTH OF STAY (in this place) <u>1 hr. 5 min.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
TOWN <u>Easton</u>				TOWN <u>Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Baby Girl Edwards</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>19</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>12-19-55</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US 4</u>	
13. FATHER'S NAME <u>Lawrence Edwards</u>				14. MOTHER'S MAIDEN NAME <u>Adeline Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS <u>Adeline Edwards</u>			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>1 hr. 5 min.</u>	
IMMEDIATE CAUSE (A) <u>In ovum</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Left ovary cystic. Removal Sept 55 - Corpus luteum in the ovary.</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Birth weight 22 oz.</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		<u>Easton</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-19-55</u> to <u>12-19-55</u> , that I last saw the deceased alive on <u>12-19-55</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. F. Buell</u>		M.D. <u>Easton</u>		ADDRESS (Street, city, town, state) <u>Ind</u>		DATE SIGNED <u>12-20-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/22/55</u>		NAME OF CEMETERY OR CREMATORY <u>Richards</u>		LOCATION (City, town, or county) (State) <u>Easton Md</u>	
24. REC'D BY REGISTRAR <u>DATE 12/20/55</u>		REGISTRAR'S SIGNATURE <u>N. H. Neerue</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James Blackwell</u>		ADDRESS <u>Easton, Md.</u>	

RECEIVED

DEC 28 1955

BUREAU V. S.

12376

CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Talbot</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Talbot</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>EASTON</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>EASTON Grassville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>FASSETT</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec 18</u> 19 <u>55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>12-18-55</u>
9. AGE last birthday		IF UNDER 1 YEAR	IF UNDER 24 HRS.
0 yrs.		Months 0 Days 0	Hours 0 Min. 0
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>MD</u>
13. FATHER'S NAME: <u>Littleton H. Fassett</u>		14. MOTHER'S MAIDEN NAME: <u>Malie P. Lockwood</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):		17. INFORMANT & ADDRESS: <u>Ida H. Brooks - Easton</u>	
15. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Congenital dyspnoea</u>			
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg, etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from , 19 , to , 19 , that I last saw the deceased alive on , 19 , and that death occurred at M, from the causes and on the date stated above.			
SIGNATURE <u>John M. M. M.</u> C.H.O.		DATE SIGNED <u>12-20-55</u>	
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Buried</u>		DATE THEREOF <u>12/19/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Grassville</u>		LOCATION (City, town, or county) (State) <u>Grassville Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/19/55</u>		REGISTRAR'S SIGNATURE <u>N. H. Neerier</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Littleton H. Fassett - Grassville</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BUREAU V. 2

JAN 1

RECEIVED

Item 9, Film G191 1-11-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 290

12377

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <u>Salisbury</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Salisbury</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Easton (Rural)</u>		<u>Easton Md</u>		TOWN <u>Easton (Rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>Rappe</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
<u>Call Thomas Foster</u>				<u>Dec 24 1955</u>			
5. SEX. <u>M</u>		6. COLOR OR RACE. <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>married</u>		8. DATE OF BIRTH. <u>2/04/12, 1924</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Logging</u>		10B. KIND OF BUSINESS OR INDUSTRY. <u>Sawmill</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Call Foster</u>				14. MOTHER'S MAIDEN NAME <u>Kath Faulkner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S ADDRESS <u>Call Foster (Father)</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)		<u>Brain damage.</u>				<u>Immediate</u>	
ANTECEDENT CAUSE (B)		<u>Fracture skull</u>				<u>11</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Dec 24 1955 M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR? <u>Auto</u>			
22. I hereby certify that I attended the deceased from <u>Dec 19 1955</u> , to <u>Dec 24 1955</u> , that I last saw the deceased alive on <u>Dec 19 1955</u> , and that death occurred at <u>Memorial Hospital</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dr. B. Kummer M.D.</u>		M.D. <u>Easton, Md</u>		DATE SIGNED <u>29 Dec 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec 29, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Easton Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/26/55</u>		REGISTRAR'S SIGNATURE <u>N.A. Neerier</u>		24. FUNERAL DIRECTOR <u>M.E. Neumann + Son</u>		ADDRESS <u>Easton Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11/1/1911

9

11/1/1911

12378

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY Talbot	MARYLAND	STATE Md.	COUNTY Talbot
CITY (If outside corporate limits, write RURAL OR and give nearest town) Easton	LENGTH OF STAY (In this place) few min.'s	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN (Rural) Trappe	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) Harry	(Middle) Parkes	(Last) Harris	
5. SEX: Male		6. AGE last birthday 22 yrs.	
7. COLOR OR RACE: white		8. DATE OF BIRTH: June 2, 1933	
9. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): labor		10B. KIND OF BUSINESS OR INDUSTRY: farm labor	
11. BIRTHPLACE (State or foreign country): Talbot Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME: William T. Harris		14. MOTHER'S MAIDEN NAME: Sallie R. Parks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-32-6400	
17. INFORMANT & ADDRESS: Mrs. Sallie R. Parks Harris Trappe, Md.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Brain Damage			
ANTECEDENT CAUSE (B) Fracture Skull			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY Dec. 24 1958 M.	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21F. HOW DID INJURY OCCUR? Auto	
22. I hereby certify that I attended the deceased from , 19 .. , to , 19 .. , that I last saw the deceased alive on , and that death occurred at M, from the causes and on the date stated above.			
SIGNATURE D. O. A.		DATE SIGNED 27 Dec 58	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 12-27-55	
NAME OF CEMETERY OR CREMATORY Windy Hill Cemetery		LOCATION (City, town, or county) (State) Trappe, Talbot Maryland.	
DATE REC'D BY LOCAL REGISTRAR 12/26/55		24. FUNERAL DIRECTOR ADDRESS Maurice E. Newnam & Son Easton, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians & please write the causes of death clearly and legibly.

U. S. A.

9

1900

12379 CERTIFICATE OF DEATH

12360

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>43 Easton</u>		<u>Life</u>		TOWN <u>Easton</u>		<u>47</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>107 Port st.</u>				STREET ADDRESS (If rural give location) <u>107 Port st.</u>			
3. NAME OF DECEASED (Type or Print) <u>William E. Harris</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12 6 1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4/28/02</u>		9. AGE last birthday <u>53</u> yrs.	IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Harris</u>				14. MOTHER'S MAIDEN NAME <u>Kattie Gale</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>165-12-1537</u>		17. INFORMANT & ADDRESS <u>Mrs. Anna Harris Easton Md.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
238X IMMEDIATE CAUSE (A) <u>Tumor of Cervical Vertebra - of unknown origin</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 mo.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>—</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>—</u>							
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Multiple pulmonary abscesses -</u>				2-3 da			
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-12-55</u> to <u>12-6-55</u> , that I last saw the deceased alive on <u>12-5-55</u> , and that death occurred at <u>8:00 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>William R. Winter</u> M.D.				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/10/55</u>		NAME OF CEMETERY OR CREMATORY <u>Richards</u>		LOCATION (City, town, or county) (State) <u>Easton MD</u>	
24. REC'D BY REGISTRAR <u>5</u>		REGISTRAR'S SIGNATURE <u>Mrs. N. H. Novice</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Donnell</u>		ADDRESS <u>Easton Md.</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

DEC 14 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12594

12380 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH: COUNTY <u>Talbot</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cordova</u> STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) <u>Samuel</u> (Middle) <u>Joseph</u> (Last) <u>Hopkins</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>12</u> <u>31</u> <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH: <u>Sept. 12, 1870</u>	9. AGE last birthday: <u>85</u> yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME: <u>Mr. William Hopkins</u>				
14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			15. INFORMANT & ADDRESS: <u>Mrs. Bessie Hopkins (wife)</u>				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			17. SOCIAL SECURITY NO.		18. MEDICAL CERTIFICATION		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>446X</u> (A) <u>Myocardia</u> DUE TO						<u>(?)</u>	
ANTECEDENT CAUSE (5): (B) <u>atherosclerotic nephropathy</u> DUE TO						<u>(?)</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>20th</u>, 19<u>55</u>, to <u>31st</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Dec. 31</u>, 19<u>55</u>, and that death occurred at <u>11:52</u> A.M., from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> ADDRESS <u>[Address]</u> DATE SIGNED <u>[Date]</u> M. D. <u>[M.D.]</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>1/3/56</u>		NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-2-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>J.E. Boulaes</u> ADDRESS <u>Greensboro Md.</u>			

JAN 12

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 12, Film G190, 12/12/55 bh

12398 **CERTIFICATE OF DEATH**

12361

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>TALBOT</u>		STATE <u>Md</u> COUNTY <u>Talbot</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN <u>Bozman rural</u>		TOWN <u>Bozman</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Carroll</u> (Middle) <u>Jefferson</u> (Last)				12 1 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>C</u>	<u>✓</u> SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)			Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
				<u>Unknown</u>	<u>U.S.A.</u>		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
18a. IMMEDIATE CAUSE (A)				<u>Coronary occlusion</u>			
18b. ANTECEDENT CAUSE(S) DUE TO							
18c. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
18d. STATING UNDERLYING CAUSE LAST. DUE TO							
18e. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> el work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M., from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Lewis M. DME</u> M.D.				<u>12-2-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				24. REC'D BY REGISTRAR			
25. FUNERAL DIRECTOR'S SIGNATURE				26. ADDRESS			
<u>Thorman V. Marshall</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

U. S.

REAR

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INSTRUCTIONS

1. **ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The before copy must be retained by the hospital or attending physician.

2. **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12399 CERTIFICATE OF DEATH

12362

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>TALBOT</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>TALBOT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>EASTON - RURAL</u>		<u>WYIS</u>		TOWN <u>EASTON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>RURAL</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>NANNIE JOHNSON</u>				(Month) (Day) (Year) <u>DEC. 15 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F.</u>	<u>C.</u>	<u>SINGLE</u>	<u>MAR. 6, 1888</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>MARYLAND</u>		<u>US</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Isaac Johnson</u>				<u>Mary Copper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>None</u>		<u>Mary Ethel Monney, Easton, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<u>Hypertensive Urine vascular disease</u>				<u>6 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 19</u> , 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE <u>Louis Mitty</u>				DATE SIGNED <u>12-20-55</u>			
M.D. <u>DME</u>				ADDRESS (Street, city, town, state) <u>Easton Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-18-55</u>		<u>Church Cemetery</u>		<u>Coppersville, Talbot Co.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>N.A. Neerues</u>		<u>Theresa E. Neerues</u>		<u>Easton Md</u>	
DATE <u>12-18-55</u>							

DEC

12381

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton, Md.</u>		LENGTH OF STAY (If in this place) <u>48 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Federalburg, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Porter Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>323 Buena Vista Ave.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) <u>Ida</u> (Middle) <u>R.</u> (Last) <u>Lane</u>				OF DEATH: <u>12</u> <u>27</u> <u>1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>March 25, 1879</u>	9. AGE last birthday: <u>76</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>H.W.</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Leonard Nichols</u>				14. MOTHER'S MAIDEN NAME: <u>Martha Nichols</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS: <u>Shirley Williams - Federalburg, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Intestinal Obstruction</u>							
ANTECEDENT CAUSE (B) <u>Carcinoma of ovary</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/10</u> , 19 <u>54</u> , to <u>12/27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/27</u> , 19 <u>55</u> , and that death occurred at <u>12:40</u> M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>Easton</u>		DATE SIGNED <u>30 Dec 1955</u>		M. D. <u>[Signature]</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		LOCATION (City, town, or county) (State) <u>Federalburg, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-28-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>Federalburg, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 9 1901

RECEIVED

12382 CERTIFICATE OF DEATH

Reg. Dist. No. 290 ...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>Easton Md.</u>		<u>3 days</u>		<u>Royal Oak, Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Memorial Hosp.</u>							
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year) OF DEATH:			
(First)		(Middle)		(Last)			
<u>Carrie</u>				<u>Leonard</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):		8. DATE OF BIRTH:	
<u>Female</u>		<u>White</u>		<u>Single</u>		<u>12/24/1863</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>92</u> yrs.		Months		Days		Hours	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				11. BIRTHPLACE (State or foreign country):			
				<u>Maryland</u>			
10B. KIND OF BUSINESS OR INDUSTRY:				12. CITIZEN OF WHAT COUNTRY?			
				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>MR Nichols Leonard</u>				<u>Mary Ellen Hampton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS:							
<u>Mrs. Marian Ferguson (niece)</u>				<u>Royal Oak, Md.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) <u>stroke</u>			
ANTECEDENT CAUSE (B)				DUE TO <u>1st CVD</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>1st CVD</u>			
				(C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
				21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/21/1955</u> , to <u>12/24/1955</u> , that I last saw the deceased alive on <u>12/24/1955</u> , and that death occurred at <u>12/24/1955</u> M, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>[Signature]</u>				<u>12/24/55</u>			
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF			
<u>Burial</u>				<u>12/26/55</u>			
NAME OF CEMETERY OR CREMATORY				LOCATION (City, town, or county) (State)			
<u>Springhill Cemetery</u>				<u>Easton, Md</u>			
DATE REC'D BY LOCAL REGISTRAR				24. FUNERAL DIRECTOR ADDRESS			
<u>12-25-55</u>				<u>N. D. Neer</u>			
REGISTRAR'S SIGNATURE				ADDRESS			
<u>[Signature]</u>				<u>Hampton, St. Michaels</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WHITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. A.

9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

12365

12383

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Isabel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>EASTON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hosp</u>		STREET ADDRESS (If rural, give location) <u>Second St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Calvert E. Merriken</u>		4. DATE OF DEATH <u>12 21 1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Nov 4 - 1887</u>
9. AGE last birthday <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY R. Merriken</u>		14. MOTHER'S MAIDEN NAME <u>Ella Conkran</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>MISSING</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Jesse R. Merriken</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Cerebral Hemorrhage. Shock.</u>		<u>9 hrs.</u>	
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Gun shot wound to head.</u>			
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Home</u> (CITY OR TOWN) <u>Denton</u> (COUNTY) <u>Caroline</u> (STATE) <u>MD</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12 24 - 55 P.M.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <u>Shot self with Pistol</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <input checked="" type="checkbox"/> natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input checked="" type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>James O. Morgan M.D. Deputy Medical Examiner</u>		DATE SIGNED <u>12/24/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>		DATE THEREOF <u>12-24-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Denton</u>		LOCATION (City, town, or county) <u>Denton</u> (State) <u>MD</u>	
DATE REC'D BY LOCAL REG. <u>12-24-55</u>		24. FUNERAL DIRECTOR <u>J. P. Brown, Denton</u> ADDRESS <u>Denton</u>	

RECEIVED

DEC 28 1955

BUREAU V. S.

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12366

12384

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Easton, Md.</u>		<u>15 hrs.</u>		TOWN <u>St. Michael</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hosp.</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Julia</u> (First) <u>Louise</u> (Middle) <u>Miller</u> (Last)				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>14</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Dec 30, 1865</u>		9. AGE last birthday <u>89</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>Sweden</u>	
13. FATHER'S NAME <u>John Hillerking</u>				14. MOTHER'S MAIDEN NAME <u>Martha Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Bishop Allen J. Miller</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial infarction</u>				<u>1 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic coronary disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/14</u>, to <u>12/14</u>, 19<u>55</u>; that I last saw the deceased alive on <u>12/14</u>, 19<u>55</u>, and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/17/55</u>		<u>Red Family Cemetery</u>		<u>Bartholomew Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DATE 12-17-55</u>		<u>N.A. Neerius</u>		<u>[Signature]</u>		<u>[Address]</u>	

W. A. S.

1917

12385

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		LENGTH OF STAY (in this place) <u>24 da.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>328 Dover Street</u>			
3. NAME OF DECEASED: (First) <u>Henrietta</u> (Middle) <u>C.</u> (Last) <u>Ried</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>12</u> <u>29</u> <u>1955</u>			
5. SEX: <u>Fe</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH: <u>Dec 1, 1870</u>	
9. AGE last birthday: <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>John Leonard</u>				14. MOTHER'S MAIDEN NAME: <u>Josephine Streets</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Granny Eason (Niece)</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				IMMEDIATE CAUSE (A) DUE TO <u>Anterior-Sciatic root disease</u>			
ANTECEDENT CAUSE (B) DUE TO				(C) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 1953, to <u>12-29</u> , 1955, that I last saw the deceased alive on <u>Dec 29</u> , 1955, and that death occurred at <u>7:15</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Donald A. Bentley</u>		M. D. <u>Easton, Md.</u>		DATE SIGNED <u>12-29-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/31/55</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		LOCATION (City, town, or county) (State) <u>Easton</u> <u>MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-30-55</u>		REGISTRAR'S SIGNATURE <u>M. D. Bentley</u>		24. FUNERAL DIRECTOR <u>Pauline C. Woodward</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BUREAU V. S.

1936

RECEIVED

12400 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Talbot		MARYLAND		STATE Md.		COUNTY Talbot	
CITY (If outside corporate limits, write OR and give nearest town)		RURAL LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN Oxford		18 yrs.		TOWN Oxford			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Oxford				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) Daniel (Middle) L. (Last) Roach				OF DEATH: Dec. 20 19 55			
5. SEX: Male		6. COLOR OR RACE: white		7. SINGLE. MARRIED. WIDOWED, DIVORCED. (Specify): married		8. DATE OF BIRTH: Nov. 20, 1896	
9. AGE last birthday: 59 yrs.		10. KIND OF BUSINESS OR INDUSTRY: Mgr. Eastern Shore Utilities		11. BIRTHPLACE (State or foreign country): Neb.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME: James Roach				14. MOTHER'S MAIDEN NAME: Honora Cahill			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) yes W. W. #1				16. SOCIAL SECURITY NO. 216-07-7031		17. INFORMANT & ADDRESS: Mrs. Mabel Roach Oxford, Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						6 months	
IMMEDIATE CAUSE (A) BRONCHOGENIC CARCINOMA							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 1955 , to Dec. 1955 , that I last saw the deceased alive on 12/19 , 1955, and that death occurred at 3:55 P.M. from the causes and on the date stated above.							
SIGNATURE Shepard Kiehn Jr.		M. D. Easton, Md.		DATE SIGNED 12/21/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-23-55		NAME OF CEMETERY OR CREMATORY Oxford Cemetery		LOCATION (City, town, or county) (State) Oxford, Talbot, Md.	
DATE REC'D BY LOCAL REGISTRAR 12/21/55		REGISTRAR'S SIGNATURE N. H. Newnam		24. FUNERAL DIRECTOR Maurice E. Newnam & Son		ADDRESS Easton, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 28 1955

RECEIVED

1

INSTRUCTIONS

1 **VS ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12386 **CERTIFICATE OF DEATH**

12369

Reg. Dist. No. 290

Item 7. Film 91 1-5-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton</u>		LENGTH OF STAY (in this place) <u>40 hrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Preston R 7 D #1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u></u>			
3. NAME OF DECEASED (Type or Print) <u>Forest Ferdinand Russell</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>15</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb. 21 1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Mr. George M. Russell</u>				14. MOTHER'S MAIDEN NAME <u>Emma G. Prairie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>(Yes, give war or dates of service)</u>			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. R E Sheerin</u>		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Chronic Congestive Heart Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease & Hypertension</u>						<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u></u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u></u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/25</u> , 19 <u>53</u> , to <u>12/5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 15</u> , 19 <u>55</u> , and that death occurred at <u>8:15</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Preston Md.</u>		DATE SIGNED <u>12/15/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		DATE THEREOF <u>Dec. 19, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Silverbush</u>		LOCATION (City, town, or county) (State) <u>Wilmington Del.</u>	
24. REC'D BY REGISTRAR DATE <u>12-19-55</u>		REGISTRAR'S SIGNATURE <u>N. H. Newkirk</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Leonard</u>		ADDRESS	

W. A. 211221

DEC

1941

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12370

12387

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Talbot</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Caroline</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
40 TOWN <i>Easton</i>		3 days 6 hrs 55 min		TOWN <i>Federalburg</i>		05 x 2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
80 Memorial Hospital							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
J. C. Satterfield				12 4 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
M	white	married	May 13 1885	70 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					Maryland		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Mr. John Satterfield				Maudie Sullivan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		2 18-16-8461		Mrs. O. Satterfield (wife)			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
610X IMMEDIATE CAUSE (A)				Leukemia			
ANTECEDENT CAUSE(S) DUE TO				Hypertension			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO				Hypertrophy of prostate			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/30, 1955, to 12/4, 1955, that I last saw the deceased alive on 12/4, 1955, and that death occurred at 5:57 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
J. J. Brampton				Federalburg, Md.		4 Dec 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		12/7/55		Pleasant Crest		Federalburg Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 12/5/55		N. H. Neerew		J. J. Brampton		Federalburg, Md.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A11C 1-55 10M



12388

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>TALBOT</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>EASTON</u>		<u>2 days</u>		TOWN <u>EASTON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hosp. Tal</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Marian V.R. Schuyler</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12 20 19 55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married Jan 14 1896</u>		8. DATE OF BIRTH <u>5-9</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. Sidney Schuyler</u>				14. MOTHER'S MAIDEN NAME <u>Corra Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>4-NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. J. Ramsey Speer, Sr. Easton, Md.</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1407 IMMEDIATE CAUSE (A) <u>Abdominal</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Nephrosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cardiac hypertrophy</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., and that death occurred at <u>4:47 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Easton, Md.</u> DATE SIGNED <u>20 Dec 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>12/24/55</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Easton, Md.</u>	
24. REC'D BY REGISTRAR <u>N.H. Neer</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	
DATE <u>12-22-55</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

DEC 28 1955

BUREAU V. S.

12389 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton, MD</u>			
TOWN <u>Easton</u>		<u>8 days</u>		STREET ADDRESS (If rural give location) <u>408 August Street</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Betty Sharp</u>				<u>Dec. 29 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Sept 13 1885</u>	9. AGE last birthday: <u>70</u> yrs	10. IF UNDER 1 YEAR: Months Days Hours Mins.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James L. Andrew</u>				14. MOTHER'S MAIDEN NAME: <u>Martha Wooters</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Laura Patchett (sister)</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>408 August St. Easton MD</u>			
IMMEDIATE CAUSE (A) <u>Dissolving a - myoma</u>				<u>12/23/55</u>			
ANTECEDENT CAUSE (B) <u>Arteriosclerosis, generalized</u>				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/29</u> , 19 <u>55</u> , to <u>12/29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/29</u> , 19 <u>55</u> , and that death occurred at <u>8:15</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>[Signature]</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>12/31/55</u>		<u>Kidgley Cemetery</u>		<u>Kidgley Cove MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12-30-55</u>		<u>N.A. Heeruv</u>		<u>Maunice Heeruv</u>		<u>1001</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BOULEVARD A. C.

1-6

1-6

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12373

12390 **CERTIFICATE OF DEATH**

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>TALBOT</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>TALBOT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		LENGTH OF STAY (In this place) <u>40 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EARL AVE</u>				STREET ADDRESS (If rural give location) <u>EARL AVE</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ETHEL</u> (Middle) <u>ELIZABETH</u> (Last) <u>SIGMAN</u>				(Month) <u>DEC</u> (Day) <u>19</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>FEB. 12, 1887</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>THEODORE NARNEY</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN (UNKNOWN)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Mrs. Dorothy Keator, Easton Md.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>I.H.C.V.D.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1945</u> , to <u>12/19/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/11/55</u> , 19 <u>55</u> , and that death occurred at <u>3:20</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Easton Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>12-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>SPRINGHILL Cemetery</u>		LOCATION (City, town, or county) (State) <u>EASTON TALBOT MD.</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>MAURICE E. ELLAMISON</u>		ADDRESS <u>Easton Md.</u>	

RECEIVED

DEC 28 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 2 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy, of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12374

12391 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Salto</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Caroline</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Easton</i>		LENGTH OF STAY (in this place) <i>3 days 3 hrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Greensboro</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Memorial Hospital</i>				STREET ADDRESS (If rural give location) <i>✓</i>			
3. NAME OF DECEASED (First) (Middle) (Last) <i>W. Notle Sippli</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>12 19 1955</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Oct 16, 1896</i>		9. AGE last birthday <i>59</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Processing man</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pet milk Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Henry Sippli</i>				14. MOTHER'S MAIDEN NAME <i>Mary Addie Jothron</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>✓</i>		16. SOCIAL SECURITY NO. <i>✓</i>		17. INFORMANT & ADDRESS <i>Mrs Anna Sippli</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>M7 E/p/plexy</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>2 yrs</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>14-C-V-D.</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/16, 1955</i> to <i>12/19, 1955</i> , that I last saw the deceased alive on <i>12/19, 1955</i> , and that death occurred at <i>10:25 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>✓</i>		M.D. <i>Seaton</i>		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12/23/55</i>		NAME OF CEMETERY OR CREMATORY <i>Greensboro</i>		LOCATION (City, town, or county) (State) <i>Greensboro, Md.</i>	
24. REC'D BY REGISTRAR DATE <i>12-22-55</i>		REGISTRAR'S SIGNATURE <i>N.A. Neerix</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>J.E. Boulais</i>		ADDRESS <i>Greensboro, Md.</i>	

RECEIVED

DEC 28 1965

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12375

12392

CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>TALBOT</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <u>EASTON</u>		<u>16 days</u>		TOWN <u>Chester</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Joseph Richard Sparks</u>				OF DEATH: <u>12</u> <u>23</u> <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Widow of March 28-1879</u>		8. DATE OF BIRTH: <u>76</u> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Gasoline Engineer</u>		9. AGE last birthday		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>	
				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME: <u>Joseph Sparks</u>				14. MOTHER'S MAIDEN NAME: <u>Rebecca Howell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS: <u>Mrs Naomi Crouch (Chester Md)</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) <u>Carcinoma of gastro-intestinal tract, site indeterminate</u>			
ANTECEDENT CAUSE (S):				(B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) DUE TO			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
				<u>No operations</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/7</u> , 19 <u>55</u> , to <u>12/23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/23</u> , 19 <u>55</u> , and that death occurred at <u>6:20 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. S. Noble</u>				ADDRESS <u>Easton Md</u>		DATE SIGNED <u>12/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>				DATE THEREOF <u>12-28-55</u>		NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>	
						LOCATION (City, town, or county) (State) <u>Centerville Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-25-55</u>				REGISTRAR'S SIGNATURE <u>N. H. Neenan</u>		24. FUNERAL DIRECTOR <u>Barton Bros. Centerville Maryland</u>	

21 DAY

9

1. The first part of the document is a list of names and addresses, which appears to be a directory or a list of contacts. The names are written in a cursive script, and the addresses are listed below them. The list includes names such as "J. H. Smith", "W. J. Jones", and "M. J. Brown", among others.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 2 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

12376

12393

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Easton, Md.</u>		<u>17 hrs.</u>		TOWN <u>Bozman, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Theodore</u> (Middle) (Last) <u>Steilkie</u>				(Month) (Day) (Year) <u>12-14-1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Oct 17, 1884</u>	<u>71</u> yrs.	Months	Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>waterman</u>				<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Gustav Steilkie</u>				<u>Henrietta Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mrs Hattie Steilkie</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>myocardial infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerotic C.V.D.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>52</u> , to <u>12-14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-14</u> , 19 <u>55</u> , and that death occurred at <u>1:45</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>M.D. St Michaels Md</u>		DATE SIGNED <u>12-14-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/17/55</u>		<u>Bozman Cemetery</u>		<u>Bozman, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>12-17-55</u>		<u>W.H. Neerius</u>		<u>Stamilton Harrison</u>		<u>St Michaels Md</u>	

1. The first group of people who are not in the labor force are those who are not in the labor force for any reason. This group includes people who are not in the labor force because they are not in the labor force for any reason.

230

1940

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 48 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12394

CERTIFICATE OF DEATH

12377

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Talbot		MARYLAND		STATE Maryland		COUNTY Talbot	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN Easton		25 yrs.		TOWN Easton, Maryland.		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				Goldsboro St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
Willy Hardcastle Stevens				Dec. 19, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	widowed	Nov. 4, 1868	87 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
School teacher		retired teacher		Mississippi.		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
A. B. Hardcastle				Alice Hatch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		none		Miss. Mary Hardcastle, Easton.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)				Branchio pneumonia			
ANTECEDENT CAUSE(S) DUE TO				Upper Respiratory Infection			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST DUE TO				General debility			
(C)				Rheumatoid Arthritis			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-1-1955, to 12-19-1955, that I last saw the deceased alive on 12-19-1955, and that death occurred at 6:50 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
MARTIN J. BULL				Easton, Maryland			
M.D.				DATE SIGNED 12-19-55			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Cremation		12/20/55		Fort Lincoln Crematory		Washington, D.C.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 12/18/55		N. A. Neer		Easton Md			

BUREAU V. S.

DEC 28 1939

RECEIVED

12401 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>talbot</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>talbot</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
TOWN <u>trappe</u>	<u>Life</u>	<u>trappe</u> (Rural)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	(If rural give location)
<u>Route 112</u>		<u>Rt 112</u>	

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First)	(Middle)	(Last)	
<u>Lorraine A.</u>	<u>Thomas</u>		
5. SEX:		6. DATE OF BIRTH:	
<u>Female</u>		<u>12/1/55</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. AGE last birthday	
<u>Single</u>		<u>21</u> yrs.	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Earl Thomas</u>		<u>Marjorie Tilghman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S NAME:		17. INFORMANT'S ADDRESS:	
		<u>Mr. Earl Thomas, Trappe, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) <u>Broncho pneumonia</u>	
ANTECEDENT CAUSE (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
<u>U</u>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/22/55, 19 55, to 12/23/55, 19 55, that I last saw the deceased alive on 12/22/55, and that death occurred at 12/23/55 M, from the causes and on the date stated above.

SIGNATURE Louis M. Myers ADDRESS 1221m 112d DATE SIGNED 12-23-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>12/23/55</u>	<u>Richards</u>	<u>Easton, MD</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>12/23/55</u>	<u>N. H. Newer</u>	<u>James B. Bicknell</u>	<u>Easton, Md.</u>

RECEIVED

DEC 28 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12379

12395

CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Trappe</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hosp.</u>		<u>11 days</u>		STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>DAISY</u> <u>Wilson</u>				<u>12</u> <u>26</u> <u>1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH:	9. AGE last birthday: <u>71</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Alex Brummell</u>				14. MOTHER'S MAIDEN NAME: <u>Clara Green</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Lester Wilson (son)</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>							
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>12/15</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/15</u> , 19 <u>55</u> , to <u>12/26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/26</u> , 19 <u>55</u> , and that death occurred at <u>4:40 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>[Signature]</u>		DATE SIGNED <u>30 Dec 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/29/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Trappe Cemetery</u>		LOCATION (City, town, or county) (State) <u>Trappe, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/27/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Harbert M. St. Charles</u>		ADDRESS <u>Camb, Md.</u>	

DEPARTMENT OF JUSTICE

BUREAU V. S.

JAN 6 1956

RECEIVED

12396

CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Easton</u>		LENGTH OF STAY (in this place) <u>D.O.A.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Denton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>05X-24</u>			
3. NAME OF DECEASED: (First) <u>James</u> (Middle) <u>L</u> (Last) <u>Wright, Jr.</u>				4. DATE OF DEATH: (Month) <u>Dec.</u> (Day) <u>28</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, <u>MARRIED</u> , WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH: <u>Nov. 1, 1922</u>	9. AGE last birthday <u>33</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Merchant</u>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <u>James L. Wright, Sr.</u>				14. MOTHER'S MAIDEN NAME: <u>Ida Timmons</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>							4 hrs.
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Dec. 28, 1955</u> , to <u>Dec. 28, 1955</u> , that I last saw the deceased alive on <u>Dec. 28, 1955</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>E. Paul Kuo</u>			M.D. <u>Denton Md</u>		DATE SIGNED <u>12-30-55</u>		
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (SPECIFY) <u>Dec. 31, 1955</u>			NAME OF CEMETERY OR CREMATORY <u>Denton</u>		LOCATION (City, town, or county) (State) <u>Denton, Md.</u>		
DATE REC'D BY LOCAL REGISTRAR <u>12-29-55</u>			REGISTRAR'S SIGNATURE <u>N.H. Neer</u>		24. FUNERAL DIRECTOR ADDRESS <u>J. Virgil Swanson Denton</u>		

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 10 1911

RECEIVED